

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2012 12:00:C
NAME OF PROVIDER OR SUPPLIER  MEMORIAL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 213 US 231 JASPER, IN47546		
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G0000	<p>This was a federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 1-10-12 through 1-13-12</p> <p>Facility #: 005990</p> <p>Medicaid Vendor #: 100265600A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>The agency had 380 skilled patients, 6 home health aide only patients, and 0 personal service patients for a total of 386 current patients.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 20, 2012</p>	G0000			
G0121	The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G0124	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure it had provided care in accordance with its own policies in 1 (#8) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's 3-22-11 "Wound Assessment &amp; Measurement" policy states, "All open wounds should be measured at least weekly to determine progress toward healing."</li> <li>2. Clinical record number 8 evidenced the presence of an open wound on the patient's left foot at the amputation site. The record failed to evidence the wound had been measured the weeks of 12-25-11 and 1-8-12.</li> <li>3. The administrator, employee G, stated, on 1-13-12 at 10:15 AM CT, "There are no wound measurements the weeks of 1-25-11 or 1-8-12."</li> </ol> <p>Administrative and supervisory functions are not delegated to another agency or organization.</p>	G0121	<p>1. The Clinical Supervisor held an inservice for the nurses on 1-24-2012 and reviewed the department policy on "Wound Assessment and Measurement" and emphasized the need for weekly wound measurements in the medical record. All nurses are to measure wounds the first visit of each week. 2. 10% of or 5 wound care charts (which ever is greater) will be audited quarterly for evidence that all wounds have weekly measurements in the medical record. A review of the "Wound Assessment and Measurement" policy will be done annually.3. The Admission/QACoordinator is responsible for the clinical record review and reporting to Administrator. Clinical Supervisor is responsible for annual policy review. Administrator is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012	

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	<p>Based on administrative record review and interview, the agency failed to ensure therapists that provided home health services reported to and were supervised by home health agency staff creating the potential to affect the 27 current patients that receive therapy services."</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During the entrance conference, on 1-10-12 at 9:55 AM CT, the administrator, employee G, indicated the agency is hospital based.</li> <li>2. The agency's "Memorial Hospital and Health Care Center Memorial Home Care Organizational Chart March 2011" evidenced the physical, occupational, and speech therapists all report to the Rehabilitation Director at the hospital.</li> <li>3. The administrator indicated, on 1-13-12 at 10:40 AM CT, the therapists that provide services on behalf of the agency report to and are supervised by a hospital employee, the Rehabilitation Director. The administrator stated, "The therapists report to a hospital employee. We do not supervise the therapists [that provide home health services]."</li> </ol>	G0124	<p>1. The Home Care Organizational chart was revised on 1-23-2012 to identify that the therapists are supervised by Rehab and Home Care. The Home Care Director and Rehab Director will keep a log of monthly conversations regarding Rehab staff. 2. Home Care Director will create a reminder on calendar to assure that the Home Care and Rehab Director discuss Home Care monthly.3. The administrator is responsible for monitoring that the Rehab staff providing home health servies are supervised by home health agency staff.</p>	02/10/2012	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/03/2012

FORM APPROVED

OMB NO. 0938-0391

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G0158	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.						

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	<p>Based on clinical record and agency policy review and interview with agency staff, the agency failed to ensure treatments had been completed as ordered on the plan of care in 2 (#s 5 and 7) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a physician order dated 11-22-11 that identified the dressing to a wound on the patient's left lower extremity was to be changed every 3 days.</p> <p>A. The record included a skilled nurse (SN) visit note dated 12-1-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-7-11, a period of 6 days between dressing changes.</p> <p>B. The record included a SN visit note dated 12-23-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-27-11, a period of 4 days between dressing changes.</p> <p>C. The record evidenced the dressing</p>	G0158	<p>1. Deficiency was reviewed at a nursing inservice on 1-24-2012. An order was added to the software stating that the Patient/Caregiver may perform ordered wound care on days no SNV made. This will be added to the Plan of Care when the patient/caregiver are to perform the dressing change. The wound care teaching and patient/caregiver competence will be documented in the clinical record. A statement was also added to software 2-1-2012 to be used when the Wound Clinic teaches the patient/caregiver the wound care. 2. 10% of or 5 wound care charts (which ever is greater) will be audited quarterly for evidence that all wounds care follows the written plan of care as established by a doctor of medicine, osteopathy, or podiatric medicine.3. The Admission/QA Coordinator is responsible for the clinical record review and reporting to Administrator. Administrator is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012	

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	<p>had been changed at the wound clinic on 1-2-12. The record evidenced the dressing had not been changed again until 1-6-12, a period of 4 days between dressing changes.</p> <p>D. The administrator, employee G, and the supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on 1-13-12 at 9:50 AM CT and just prior to the exit conference on 1-13-12 at 1:30 PM CT.</p> <p>2. Clinical record number 7 included a physician order dated 11-28-11 that identified dressing changes were to be performed every other day to abrasions/ulcers on the patient's bilateral upper extremities.</p> <p>A. Skilled nurse visit notes, dated 11-29-11, 12-1-11, 12-5-11, 12-13-11, 12-21-11, 12-29-11, 12-31-11, 1-4-12, 1-6-12, and 1-11-12, failed to evidence the dressing changes had been completed or that the nurse had taught the patient and/or caregiver how to change the dressings and that they were performing them.</p> <p>B. The supervising nurse, employee H, indicated, on 1-13-12 at 10:30 AM CT,</p>				

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G0164	<p>the visit notes did not evidence any documentation regarding the upper extremity wounds.</p> <p>3. The agency's September 2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by a doctor or medicine, osteopathy, or podiatric medicine."</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p>				

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure the physician had been notified of a change in a patient's status in 1 (# 2) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 12-13-11 to 02-10-12 that identified the patient had a postoperative infection and was on Vancomycin (an antibiotic) 1000 milligrams intravenously.</p> <p>A. The record included a start of care skilled nurse (SN) visit note dated 12-13-11 that identified the presence of a surgical incision on the left knee. The note stated, "Healing: Edges well approximated, Staples / Sutures intact" with a "moderate" amount of drainage.</p> <p>B. The record included a "Charts / Clinical Notes" dated 12-14-11 that states, "Pt [patient] also c/o [complained of] knee incision bleeding more that usual."</p> <p>C. The record included a SN visit note dated 12-15-11 that states, "Pt had saved</p>	G0164	<p>1. This deficiency and department policy "Medical Supervision / Plan of Care" was reviewed with staff at meetings on 1-24-2012 and 1-26-2012. 2. 10% of active clinical records will be audited quarterly for evidence that professional home care staff promptly alerted the physician to any changes that suggest a need to alter the plan of care.3. The Admission/QA Coordinator is responsible for the chart review and reporting the results to the Administrator who is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012			

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	<p>drsg [dressing] removed last evening after pt completes CPM [continuous passive motion] and note large amount of SS [serosanguinous] drng [drainage] to drsg."</p> <p>D. A "Charts / Clinical Notes" dated 12-16-11 states, "Pt called requesting nurse visit before 3:30 PM. States knee incision is draining 'excessively' . . . Called LR, RN, who saw pt yesterday to inquire about incision and drainage. States incision was very edematous [swollen] and somewhat red; not warm . . . dressing pt had saved from previous evening after CPM exercise had a large amt [amount] of sersanguinous [sic] drainage."</p> <p>E. A "Charts / Clinical Notes" dated 12-19-11 states, "Patient called. Reports [patient] is concerned about [patient's] incision line. There is an area that is gray in color. Drainage is a little less but still a lot . . . [Patient] tected [sic] a picture of [the patient's] wound to my cell phone. [The patient's] RN Case Manager reviewed the pictures with me. Area around one suture is very puffy (cannot see the end of one of the sutures). The incision line appears to be separating. I called the patient backed [sic] and told [the patient] that we felt [the patient] needed to call [the patient's] surgeon."</p>						

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	<p>F. A SN visit note dated 12-20-11 states, "Suture line mid knee has opened slightly."</p> <p>G. A SN visit note dated 12-22-11 states, "L [left] knee larger than admission, noted incision line starting to dehiss [sic] sutures in place, had MD visit yesterday . . . but only seen nurse . . . no new orders. Client to make another appt [appointment] for Monday to see [physician's name]."</p> <p>H. A SN visit note dated 12-29-11 states, "Dehischence [sic] throughout sutures."</p> <p>I. A "Charts / Clinical Notes" dated 1-9-12 states, "Pt . . . reports 'I've been having a tremendous amount of drainage to TKR [total knee replacement site to small area between sutures / staples. Changed drsg to site x 3 yesterday . . . Pt requesting primary RN."</p> <p>J. The record failed to evidence the RN had contacted the physician to report the increased drainage, the patient's concerns, or the separation of the incision line</p> <p>2. The supervising nurse, employee H,</p>						

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G0170	<p>indicated, on 1-13-12 at 10:30 AM CT, the record did not evidence the physician had been notified of the change in the patient's knee incision.</p> <p>3. The agency's September 2006 "Physician Communication" policy states, "The Physician is informed of any changes in the patient's condition and Physician orders shall be obtained as indicated."</p> <p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p>				

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	<p>Based on clinical record and agency policy review and interview with agency staff, the registered nurse failed to ensure treatments had been completed as ordered on the plan of care in 2 (#s 5 and 7) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a physician order dated 11-22-11 that identified the dressing to a wound on the patient's left lower extremity was to be changed every 3 days.</p> <p>A. The record included a skilled nurse (SN) visit note dated 12-1-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-7-11, a period of 6 days between dressing changes.</p> <p>B. The record included a SN visit note dated 12-23-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-27-11, a period of 4 days between dressing changes.</p> <p>C. The record evidenced the dressing</p>	G0170	<p>1. Deficiency was reviewed at a nursing inservice on 1-24-2012. An order was added to the software stating that the Patient/Caregiver may perform ordered wound care on days no SNV made. This will be added to the Plan of Care when the patient/caregiver are to perform the dressing change. The wound care teaching and patient/caregiver competence will be documented in the clinical record. A statement was also added to software 2-1-2012 to be used when the Wound Clinic teaches the patient/caregiver the wound care. 2. 10% of or 5 wound care charts (which ever is greater) will be audited quarterly for evidence that all wound care provided by nursing follows the written plan of care. 3. The Admission/QA Coordinator is responsible for the clinical record review and reporting to Administrator. Administrator is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012	

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	<p>had been changed at the wound clinic on 1-2-12. The record evidenced the dressing had not been changed again until 1-6-12, a period of 4 days between dressing changes.</p> <p>D. The administrator, employee G, and the supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on 1-13-12 at 9:50 AM CT and just prior to the exit conference on 1-13-12 at 1:30 PM CT.</p> <p>2. Clinical record number 7 included a physician order dated 11-28-11 that identified dressing changes were to be performed every other day to abrasions/ulcers on the patient's bilateral upper extremities.</p> <p>A. Skilled nurse visit notes, dated 11-29-11, 12-1-11, 12-5-11, 12-13-11, 12-21-11, 12-29-11, 12-31-11, 1-4-12, 1-6-12, and 1-11-12, failed to evidence the dressing changes had been completed or that the nurse had taught the patient and/or caregiver how to change the dressings and that they were performing them.</p> <p>B. The supervising nurse, employee H, indicated, on 1-13-12 at 10:30 AM CT,</p>				

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G0176	<p>the visit notes did not evidence any documentation regarding the upper extremity wounds.</p> <p>3. The agency's September 2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by a doctor or medicine, osteopathy, or podiatric medicine."</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p>				

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure the physician had been notified of a change in a patient's status in 1 (# 2) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 12-13-11 to 02-10-12 that identified the patient had a postoperative infection and was on Vancomycin (an antibiotic) 1000 milligrams intravenously.</p> <p>A. The record included a start of care skilled nurse (SN) visit note dated 12-13-11 that identified the presence of a surgical incision on the left knee. The note stated, "Healing: Edges well approximated, Staples / Sutures intact" with a "moderate" amount of drainage.</p> <p>B. The record included a "Charts / Clinical Notes" dated 12-14-11 that states, "Pt [patient] also c/o [complained of] knee incision bleeding more that usual."</p> <p>C. The record included a SN visit note dated 12-15-11 that states, "Pt had saved</p>	G0176	<p>1. This deficiency and department policy "Medical Supervision / Plan of Care" was reviewed with all staff at meeting on 1-24-2012 and 1-26-2012. 2. 10% of active clinical records will be audited quarterly for evidence that registered nurse promptly alerted the physician and other personnel of changes in the patient's condition and needs.3. The Admission/QA Coordinator is responsible for the chart review and reporting the results to the Administrator who is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012			

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NAME OF PROVIDER OR SUPPLIER  MEMORIAL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 213 US 231 JASPER, IN47546		
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	<p>drsg [dressing] removed last evening after pt completes CPM [continuous passive motion] and note large amount of SS [serosanguinous] drng [drainage] to drsg."</p> <p>D. A "Charts / Clinical Notes" dated 12-16-11 states, "Pt called requesting nurse visit before 3:30 PM. States knee incision is draining 'excessively' . . . Called LR, RN, who saw pt yesterday to inquire about incision and drainage. States incision was very edematous [swollen] and somewhat red; not warm . . . dressing pt had saved from previous evening after CPM exercise had a large amt [amount] of sersanguinous [sic] drainage."</p> <p>E. A "Charts / Clinical Notes" dated 12-19-11 states, "Patient called. Reports [patient] is concerned about [patient's] incision line. There is an area that is gray in color. Drainage is a little less but still a lot . . . [Patient] tected [sic] a picture of [the patient's] wound to my cell phone. [The patient's] RN Case Manager reviewed the pictures with me. Area around one suture is very puffy (cannot see the end of one of the sutures). The incision line appears to be separating. I called the patient backed [sic] and told [the patient] that we felt [the patient] needed to call [the patient's] surgeon."</p>				

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	<p>F. A SN visit note dated 12-20-11 states, "Suture line mid knee has opened slightly."</p> <p>G. A SN visit note dated 12-22-11 states, "L [left] knee larger than admission, noted incision line starting to dehiss [sic] sutures in place, had MD visit yesterday . . . but only seen nurse . . . no new orders. Client to make another appt [appointment] for Monday to see [physician's name]."</p> <p>H. A SN visit note dated 12-29-11 states, "Dehischence [sic] throughout sutures."</p> <p>I. A "Charts / Clinical Notes" dated 1-9-12 states, "Pt . . . reports 'I've been having a tremendous amount of drainage to TKR [total knee replacement site to small area between sutures / staples. Changed drsg to site x 3 yesterday . . . Pt requesting primary RN."</p> <p>J. The record failed to evidence the RN had contacted the physician to report the increased drainage, the patient's concerns, or the separation of the incision line</p> <p>2. The supervising nurse, employee H,</p>				

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G0236	<p>indicated, on 1-13-12 at 10:30 AM CT, the record did not evidence the physician had been notified of the change in the patient's knee incision.</p> <p>3. The agency's September 2006 "Physician Communication" policy states, "The Physician is informed of any changes in the patient's condition and Physician orders shall be obtained as indicated."</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p>				

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure clinical records included signed clinical and progress notes in 1 (# 10) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 10 included medical social services clinical notes, dated 11-29-11, 1-1-11, and 12-6-11, that failed to evidence the medical social worker's signature.</li> <li>2. The administrator, employee G, stated, on 1-13-11 at 8:55 AM CT, "The medical social worker did not sign the note. Her name is [employee I]."</li> <li>3. The agency's May 2004 "MI12 Contents of Medical Records" policy states, "Each Home Care record whether paper form of computerized contains the following when applicable: . . . Notes indicating the date, staff person, and care or service provided."</li> </ol>	G0236	<ol style="list-style-type: none"> <li>1. On 1-17-2012, administrator reviewed deficiency with the medical social worker and reviewed with her how to electronically sign a clinical note when not making a visit to the patient. Clinical Supervisor reviewed this deficiency with the other staff on 1-24-2012.</li> <li>2. 10% of active clinical records will be audited quarterly for evidence that all clinical notes are signed.</li> <li>3. The Admission/QA Coordinator is responsible for the chart review and reporting the results to the Administrator who is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</li> </ol>	02/10/2012	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/03/2012

FORM APPROVED

OMB NO. 0938-0391

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N0441	Rule 12 Sec. 1(a) Administrative and supervisory responsibilities shall not be delegated to another agency or organization, and all services not furnished directly, including services provided through a branch office, shall be monitored and controlled by the parent agency.				

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	<p>Based on administrative record review and interview, the agency failed to ensure therapists that provided home health services reported to and were supervised by home health agency staff creating the potential to affect the 27 current patients that receive therapy services."</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During the entrance conference, on 1-10-12 at 9:55 AM CT, the administrator, employee G, indicated the agency is hospital based.</li> <li>2. The agency's "Memorial Hospital and Health Care Center Memorial Home Care Organizational Chart March 2011" evidenced the physical, occupational, and speech therapists all report to the Rehabilitation Director at the hospital.</li> <li>3. The administrator indicated, on 1-13-12 at 10:40 AM CT, the therapists that provide services on behalf of the agency report to and are supervised by a hospital employee, the Rehabilitation Director. The administrator stated, "The therapists report to a hospital employee. We do not supervise the therapists [that provide home health services]."</li> </ol>	N0441	<p>1. The Home Care Organizational chart was revised on 1-23-2012 to identify that the therapists are supervised and monitored by Rehab and Home Care. The Home Care Director and Rehab Director will keep a log of monthly conversations regarding Rehab staff. 2. Home Care Director will create a reminder on calendar to assure that the Home Care and Rehab Director discuss Home Care monthly.3. The administrator is responsible for monitoring that the Rehab staff providing home health servies are supervised and controlled by home health agency staff.</p>	02/10/2012	

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N0522	Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:				

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	<p>Based on clinical record and agency policy review and interview with agency staff, the agency failed to ensure treatments had been completed as ordered on the plan of care in 2 (#s 5 and 7) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a physician order dated 11-22-11 that identified the dressing to a wound on the patient's left lower extremity was to be changed every 3 days.</p> <p>A. The record included a skilled nurse (SN) visit note dated 12-1-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-7-11, a period of 6 days between dressing changes.</p> <p>B. The record included a SN visit note dated 12-23-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-27-11, a period of 4 days between dressing changes.</p> <p>C. The record evidenced the dressing</p>	N0522	<p>1. Deficiency was reviewed at a nursing inservice on 1-24-2012. An order was added to the software stating that the Patient/Caregiver may perform ordered wound care on days no SNV made. This will be added to the Plan of Care when the patient/caregiver are to perform the dressing change. The wound care teaching and patient/caregiver competence will be documented in the clinical record. A statement was also added to software 2-1-2012 to be used when the Wound Clinic teaches the patient/caregiver the wound care. 2. 10% of or 5 wound care charts (which ever is greater) will be audited quarterly for evidence that all wounds care follows the written plan of care as established by a doctor of medicine, osteopathy, or podiatric medicine.3. The Admission/QA Coordinator is responsible for the clinical record review and reporting to Administrator. Administrator is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012			

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	<p>had been changed at the wound clinic on 1-2-12. The record evidenced the dressing had not been changed again until 1-6-12, a period of 4 days between dressing changes.</p> <p>D. The administrator, employee G, and the supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on 1-13-12 at 9:50 AM CT and just prior to the exit conference on 1-13-12 at 1:30 PM CT.</p> <p>2. Clinical record number 7 included a physician order dated 11-28-11 that identified dressing changes were to be performed every other day to abrasions/ulcers on the patient's bilateral upper extremities.</p> <p>A. Skilled nurse visit notes, dated 11-29-11, 12-1-11, 12-5-11, 12-13-11, 12-21-11, 12-29-11, 12-31-11, 1-4-12, 1-6-12, and 1-11-12, failed to evidence the dressing changes had been completed or that the nurse had taught the patient and/or caregiver how to change the dressings and that they were performing them.</p> <p>B. The supervising nurse, employee H, indicated, on 1-13-12 at 10:30 AM CT,</p>				

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N0527	<p>the visit notes did not evidence any documentation regarding the upper extremity wounds.</p> <p>3. The agency's September 2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by a doctor or medicine, osteopathy, or podiatric medicine."</p> <p>Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p>				

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure the physician had been notified of a change in a patient's status in 1 (# 2) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 12-13-11 to 02-10-12 that identified the patient had a postoperative infection and was on Vancomycin (an antibiotic) 1000 milligrams intravenously.</p> <p>A. The record included a start of care skilled nurse (SN) visit note dated 12-13-11 that identified the presence of a surgical incision on the left knee. The note stated, "Healing: Edges well approximated, Staples / Sutures intact" with a "moderate" amount of drainage.</p> <p>B. The record included a "Charts / Clinical Notes" dated 12-14-11 that states, "Pt [patient] also c/o [complained of] knee incision bleeding more that usual."</p> <p>C. The record included a SN visit note dated 12-15-11 that states, "Pt had saved</p>	N0527	<p>1. This deficiency and department policy "Medical Supervision / Plan of Care" was reviewed with staff at meetings on 1-24-2012 and 1-26-2012. 2. 10% of active clinical records will be audited quarterly for evidence that professional home care staff promptly alerted the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.3. The Admission/QA Coordinator is responsible for the chart review and reporting the results to the Administrator who is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012			

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	<p>drsg [dressing] removed last evening after pt completes CPM [continuous passive motion] and note large amount of SS [serosanguinous] drng [drainage] to drsg."</p> <p>D. A "Charts / Clinical Notes" dated 12-16-11 states, "Pt called requesting nurse visit before 3:30 PM. States knee incision is draining 'excessively' . . . Called LR, RN, who saw pt yesterday to inquire about incision and drainage. States incision was very edematous [swollen] and somewhat red; not warm . . . dressing pt had saved from previous evening after CPM exercise had a large amt [amount] of sersanguinous [sic] drainage."</p> <p>E. A "Charts / Clinical Notes" dated 12-19-11 states, "Patient called. Reports [patient] is concerned about [patient's] incision line. There is an area that is gray in color. Drainage is a little less but still a lot . . . [Patient] tected [sic] a picture of [the patient's] wound to my cell phone. [The patient's] RN Case Manager reviewed the pictures with me. Area around one suture is very puffy (cannot see the end of one of the sutures). The incision line appears to be separating. I called the patient backed [sic] and told [the patient] that we felt [the patient] needed to call [the patient's] surgeon."</p>						

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	<p>F. A SN visit note dated 12-20-11 states, "Suture line mid knee has opened slightly."</p> <p>G. A SN visit note dated 12-22-11 states, "L [left] knee larger than admission, noted incision line starting to dehiss [sic] sutures in place, had MD visit yesterday . . . but only seen nurse . . . no new orders. Client to make another appt [appointment] for Monday to see [physician's name]."</p> <p>H. A SN visit note dated 12-29-11 states, "Dehischence [sic] throughout sutures."</p> <p>I. A "Charts / Clinical Notes" dated 1-9-12 states, "Pt . . . reports 'I've been having a tremendous amount of drainage to TKR [total knee replacement site to small area between sutures / staples. Changed drsg to site x 3 yesterday . . . Pt requesting primary RN."</p> <p>J. The record failed to evidence the RN had contacted the physician to report the increased drainage, the patient's concerns, or the separation of the incision line</p> <p>2. The supervising nurse, employee H,</p>				

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N0537	<p>indicated, on 1-13-12 at 10:30 AM CT, the record did not evidence the physician had been notified of the change in the patient's knee incision.</p> <p>3. The agency's September 2006 "Physician Communication" policy states, "The Physician is informed of any changes in the patient's condition and Physician orders shall be obtained as indicated."</p> <p>Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p>				

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	<p>Based on clinical record and agency policy review and interview with agency staff, the registered nurse failed to ensure treatments had been completed as ordered on the plan of care in 2 (#s 5 and 7) of 12 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a physician order dated 11-22-11 that identified the dressing to a wound on the patient's left lower extremity was to be changed every 3 days.</p> <p>A. The record included a skilled nurse (SN) visit note dated 12-1-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-7-11, a period of 6 days between dressing changes.</p> <p>B. The record included a SN visit note dated 12-23-11 that identified the nurse had changed the dressing. The record evidenced the dressing had not been changed again until 12-27-11, a period of 4 days between dressing changes.</p> <p>C. The record evidenced the dressing had been changed at the wound clinic on 1-2-12. The record evidenced the</p>	N0537	<p>1. Deficiency was reviewed at a nursing inservice on 1-24-2012. An order was added to the software stating that the Patient/Caregiver may perform ordered wound care on days no SNV made. This will be added to the Plan of Care when the patient/caregiver are to perform the dressing change. The wound care teaching and patient/caregiver competence will be documented in the clinical record. A statement was also added to software 2-1-12 to be used when the Wound Clinic teaches the patient/caregiver the wound care. 2. 10% of or 5 wound care charts (which ever is greater) will be audited quarterly for evidence that all wound care provided by a registered nurse is in accordance the medical plan of care. 3. The Admission/QA Coordinator is responsible for the clinical record review and reporting to Administrator. Administrator is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012	

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	<p>dressing had not been changed again until 1-6-12, a period of 4 days between dressing changes.</p> <p>D. The administrator, employee G, and the supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on 1-13-12 at 9:50 AM CT and just prior to the exit conference on 1-13-12 at 1:30 PM CT.</p> <p>2. Clinical record number 7 included a physician order dated 11-28-11 that identified dressing changes were to be performed every other day to abrasions/ulcers on the patient's bilateral upper extremities.</p> <p>A. Skilled nurse visit notes, dated 11-29-11, 12-1-11, 12-5-11, 12-13-11, 12-21-11, 12-29-11, 12-31-11, 1-4-12, 1-6-12, and 1-11-12, failed to evidence the dressing changes had been completed or that the nurse had taught the patient and/or caregiver how to change the dressings and that they were performing them.</p> <p>B. The supervising nurse, employee H, indicated, on 1-13-12 at 10:30 AM CT, the visit notes did not evidence any documentation regarding the upper</p>				

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N0546	<p>extremity wounds.</p> <p>3. The agency's September 2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by a doctor or medicine, osteopathy, or podiatric medicine."</p> <p>Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p>				

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure the physician had been notified of a change in a patient's status in 1 (# 2) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 12-13-11 to 02-10-12 that identified the patient had a postoperative infection and was on Vancomycin (an antibiotic) 1000 milligrams intravenously.</p> <p>A. The record included a start of care skilled nurse (SN) visit note dated 12-13-11 that identified the presence of a surgical incision on the left knee. The note stated, "Healing: Edges well approximated, Staples / Sutures intact" with a "moderate" amount of drainage.</p> <p>B. The record included a "Charts / Clinical Notes" dated 12-14-11 that states, "Pt [patient] also c/o [complained of] knee incision bleeding more that usual."</p> <p>C. The record included a SN visit note dated 12-15-11 that states, "Pt had saved</p>	N0546	<p>1. This deficiency and the department policy "Medical Supervision / Plan of Care" were reviewed with all staff at meeting on 1-24-2012 and 1-26-2012. 2. 10% of active clinical records will be audited quarterly for evidence that registered nurse informed the physician and other appropriate medical personnel of changes in the patient's condition and needs.3. The Admission/QA Coordinator is responsible for the chart review and reporting the results to the Administrator who is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</p>	02/10/2012			

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	<p>drsg [dressing] removed last evening after pt completes CPM [continuous passive motion] and note large amount of SS [serosanguinous] drng [drainage] to drsg."</p> <p>D. A "Charts / Clinical Notes" dated 12-16-11 states, "Pt called requesting nurse visit before 3:30 PM. States knee incision is draining 'excessively' . . . Called LR, RN, who saw pt yesterday to inquire about incision and drainage. States incision was very edematous [swollen] and somewhat red; not warm . . . dressing pt had saved from previous evening after CPM exercise had a large amt [amount] of sersanguinous [sic] drainage."</p> <p>E. A "Charts / Clinical Notes" dated 12-19-11 states, "Patient called. Reports [patient] is concerned about [patient's] incision line. There is an area that is gray in color. Drainage is a little less but still a lot . . . [Patient] tected [sic] a picture of [the patient's] wound to my cell phone. [The patient's] RN Case Manager reviewed the pictures with me. Area around one suture is very puffy (cannot see the end of one of the sutures). The incision line appears to be separating. I called the patient backed [sic] and told [the patient] that we felt [the patient] needed to call [the patient's] surgeon."</p>						

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	<p>F. A SN visit note dated 12-20-11 states, "Suture line mid knee has opened slightly."</p> <p>G. A SN visit note dated 12-22-11 states, "L [left] knee larger than admission, noted incision line starting to dehiss [sic] sutures in place, had MD visit yesterday . . . but only seen nurse . . . no new orders. Client to make another appt [appointment] for Monday to see [physician's name]."</p> <p>H. A SN visit note dated 12-29-11 states, "Dehischence [sic] throughout sutures."</p> <p>I. A "Charts / Clinical Notes" dated 1-9-12 states, "Pt . . . reports 'I've been having a tremendous amount of drainage to TKR [total knee replacement site to small area between sutures / staples. Changed drsg to site x 3 yesterday . . . Pt requesting primary RN."</p> <p>J. The record failed to evidence the RN had contacted the physician to report the increased drainage, the patient's concerns, or the separation of the incision line</p> <p>2. The supervising nurse, employee H,</p>				

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N0608	<p>indicated, on 1-13-12 at 10:30 AM CT, the record did not evidence the physician had been notified of the change in the patient's knee incision.</p> <p>3. The agency's September 2006 "Physician Communication" policy states, "The Physician is informed of any changes in the patient's condition and Physician orders shall be obtained as indicated."</p> <p>Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information.</p> <p>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p>						

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure clinical records included signed clinical and progress notes in 1 (# 10) of 12 records reviewed creating the potential to affect all of the agency's 85 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 10 included medical social services clinical notes, dated 11-29-11, 1-1-11, and 12-6-11, that failed to evidence the medical social worker's signature.</li> <li>2. The administrator, employee G, stated, on 1-13-11 at 8:55 AM CT, "The medical social worker did not sign the note. Her name is [employee I]."</li> <li>3. The agency's May 2004 "MI12 Contents of Medical Records" policy states, "Each Home Care record whether paper form of computerized contains the following when applicable: . . . Notes indicating the date, staff person, and care or service provided."</li> </ol>	N0608	<ol style="list-style-type: none"> <li>1. On 1-17-2012, the administrator reviewed deficiency with the medical social worker and reviewed with her how to electronically sign a clinical note when not making a visit to the patient. Clinical Supervisor reviewed this deficiency with the other staff on 1-24-2012.</li> <li>2. 10% of active clinical records will be audited quarterly for evidence that all clinical notes are signed and dated.</li> <li>3. The Admission/QA Coordinator is responsible for the chart review and reporting the results to the Administrator who is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.</li> </ol>	02/10/2012	